Ashdale House

ID Number: RES0004

24-Hour Residence – 2018 Inspection Report

Ashdale House
Terenure
Dublin

Community Healthcare Organisation:
CHO 7

Team Responsible:
General Adult

Total Number of Beds:
10

Total Number of Residents:
8

Inspection Team:
Noeleen Byrne, Lead Inspector

Inspection Date:
17 January 2018

Inspection Type:
Unannounced Inspection

The Inspector of Mental Health Services:
Dr Susan Finnerty MCRN009711

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Introduction to the Inspection Process

This inspection and report were guided by the themes contained in the Mental Health Commission Quality Framework.

Services will be aware of the Audit Toolkit deriving from the Quality Framework and may wish to consider using this Toolkit in pursuing service improvement within the residence involved.

Service description

Ashdale House, a ten-bed, 24-hour, nurse-staffed residence, was located in Terenure village, Co. Dublin. The two-storey, red-bricked residence was owned by the HSE and was originally a private residence. It opened as a community residence in 1998. At the time of inspection, Ashdale House was providing high-support continuing care services for eight residents, who were under the care of the Jonathan Swift Clinic at St. James's Hospital. At the time of the inspection, the future plan for the residence was for it to remain unchanged.

Residence facilities and maintenance

Ashdale House accommodated residents in five bedrooms. There was one single, three double, and one triple room with two occupants. There were no privacy screens between the beds in shared rooms, which did not ensure residents' privacy or dignity. The double rooms were small and cramped.

The residence had two sitting rooms and a dining room. The kitchen was kept locked. Bedroom accommodation was arranged on four levels, owing to half-landings. There was one bathroom upstairs and a toilet downstairs.

There was a backyard behind the residence but no garden. The exterior of the residence was well maintained. At the time of the inspection, the boiler had just been repaired. Additionally, a new cooker had been recently fitted and opaque film had been attached to some windows in the residence to improve privacy. Staff were not aware of any plans for renovations or refurbishments.

Resident profile

At the time of the inspection, Ashdale House was accommodating two male and six female residents. The residents were aged between their mid-40s and mid-60s. The house opened in 1998, two residents have lived in Ashdale House for many years and six were admitted in recent years.

Care and treatment

Ashdale House had a policy in relation to individual care planning, which was undergoing review at the time of inspection. The policy made available was dated March 2011. Individual care plans (ICPs) were not in place for residents. Each clinical file contained a goal sheet, which did not constitute an ICP. The goal sheets had been drawn up by the key worker in conjunction with the residents and considered evidenced based assessments including social function scale, mini mental state examination and risk assessment.

Residents regularly saw their consultant psychiatrist in the out-patient department in St. James's Hospital, at which time appointments could be arranged with other members of the multi-disciplinary team (MDT), if necessary. Alternatively, nursing staff contacted the consultant psychiatrist to request an appointment if a resident needed to meet a member of the MDT.

In some of the clinical files examined, single goals were listed for the residents; these were restated every three months over a period of two years and were repetitive in nature. Residents received a psychiatric evaluation every three months in the out-patient department in St. James's Hospital

No MDT meetings were held in the residence; they took place infrequently, in the out-patient department in St. James's Hospital. Residents could attend if they wished.

Physical care

Ashdale House had a policy in relation to physical care and general health, which was undergoing review at the time of inspection. All residents had access to GP practices in the locality. Routine physical examinations were completed on a six-monthly basis by the GPs. Residents had access to appropriate national health screening programmes, and information leaflets in relation to these programmes were available in the house.

Residents could be referred to other health care services as required. They attended a dentist of their own choice and had access to speech and language therapy through the consultant psychiatrist. Physiotherapy services were available by GP referral, and all residents had chiropody cards. Residents did not have access to a dietitian.

Therapeutic services and programmes

The residence had a policy in relation to therapeutic programmes. Residents attended a variety of programmes off-site. Some attended the Brú Chaoimhín day service for cookery classes and personal development programmes. Others participated in programmes in Thomas Court and the Cherryfield Day Centre. Two residents went swimming regularly and took aqua aerobics classes, and one resident went to set dancing classes. Nursing staff provided therapeutic activity with clients not attending day service.

The occupational therapist visited weekly and assisted residents with activities of daily living and held a cookery group.

Recreational activities

Residents in Ashdale House had access to a range of recreational activities, including TV, DVDs, a relaxation group, newspapers, and crosswords. They could also avail of local amenities in Terenure and Rathmines.

Medication

Ashdale House had a policy in relation to medication management. Medication was prescribed by the residents' GPs or the consultant psychiatrist's registrar, who attended the house regularly with a nurse from the community mental health team to review medication and update Medication Prescription Administration Records (MPARs). The MPARs contained valid prescription and administration details, but a number of gaps were identified in the records.

At the time of inspection, one resident was self-medicating and received their prescription in a blister pack. Medicines were supplied by local pharmacies and were stored appropriately and legally in locked cabinets in the office.

Community engagement

The location of Ashdale House facilitated community engagement. Residents could walk to Terenure or easily access buses to Rathmines and other localities. Residents had limited financial resources and all declined to go to the pantomime at Christmas. Other outings were arranged throughout the year.

The clinical nurse manager 2 was insured to transport people to community activities or hospital appointments by car. Residents could also use Dublin Bus or taxis. There was no community in-reach into the residence.

Autonomy

Residents did not have full and free access to the kitchen but could access under staff supervision. Residents were free to determine their bedtimes, but no resident had a key to their own bedroom.

Residents helped out with domestic chores, and a roster of duties was in place. Household staff supported residents to do their laundry. Residents could come and go as they wished. They were free to receive visitors at any time.

Staffing

Staff Discipline	Day whole-time equivalent (WTE)	Night WTE
Clinical Nurse Manager 2	1	
Registered Psychiatric Nurse	1	1
Multi-Task Attendant	1	

Team input (Sessional)

Discipline	Number of sessions
Occupational Therapist	One day a week
Social Worker	0
Clinical Psychologist	0

Medical Staff	Frequency of attendance at residence
Consultant Psychiatrist	0
Non-Consultant Hospital Doctor	By request

Staff had received training in Basic Life Support, fire safety, and Management of Actual or Potential Aggression. Agency staff were trained in breakaway techniques.

Complaints

Ashdale House had a complaints policy, and residents were aware of how to make a complaint. Residents brought minor complaints to staff, who addressed them as they arose. Where a complaint required escalation, the assistant director of nursing (ADON) dealt with it. There was a complaints log in the residence. There was a suggestion box in the sitting room and pen and paper was provided. All suggestions were discussed monthly community meetings were held in the residence, and minutes of these were maintained.

Risk management and incidents

Ashdale House had a risk management policy, and all residents were routinely risk-assessed. Incidents were documented and reported using a form that was forwarded to the ADON.

The residence appeared to be physically safe. The fire extinguishers were serviced regularly and in date. A first aid kit and an Automated External Defibrillator (AED) were kept on the premises.

Financial arrangements

Ashdale House had a policy in relation to managing residents' finances. The charge for residents was between €115 and €175 per week, which included rent, food, and utilities. This was paid by direct debit. Residents had bank or post office accounts. Appropriate procedures were in place in relation to staff handling residents' money.

Residents did not contribute to a kitty or social fund, and residents' finances had not been audited.

Service user experience

All residents were in the house at the time of the inspection. Residents explained that additional heaters had been brought in to the house as the central heating was broken. They said they were warm enough and the boiler was being repaired. One resident had moved bedrooms and arrangements were made for the room to be decorated. One resident requested the key to the kitchen to make a cup of tea and this was facilitated. Overall residents were happy with the food and could suggest menu options.

Areas of good practice

1. An occupational therapist from the community rehabilitation mental health team attended the residence one day per week.

Areas for improvement

1. Residents had no individual care plans and there were no multi-disciplinary team meetings to develop same.

2. Operational policies had not been updated and some were last reviewed in 2011.

3. Agency staff had no access to online policies or documentation.

4. Each resident should have their own bedroom. In the meantime, privacy screens should be used where there are shared bedrooms.